in a typical case of typhoid fever. Should the temperature rise to 100.4° F. during the first two or three hours, it later oscillates between 97.2° in the morning and 99.5° in the evening, without other variation not due to complication. The pulse is variable; sometimes it is slow, more often it is normal; occasionally it is increased in frequency. It is difficult to recognize the different stages of the disease, as these are usually indicated by the course of the temperature-curve. Convalescence is sometimes protracted, the patient remaining feeble and emaciated for a long time. The same complications may arise as occur in the ordinary course of the disease. Exceptionally, cases of typhoid fever occur in which the temperature is throughout subnormal. In these the temperature-curve is usually of the inverted type, the records being highest in the morning and lowest in the evening. From a diagnostic point of view importance is to be attached to the presence of enlargement of the spleen and of rose-spots. In explanation of these apyretic forms of typhoid fever it is assumed that elimination of the infectious elements of the disease by the kidneys is imperfectly effected, and recent experimental studies have shown that the urine of patients with typhoid fever at times contains toxic bodies capable of causing depression of temperature. It is suggested that in some cases there is a preponderance in the products of the activity of the typhoid bacillus of substances capable of causing such depression. Therapeutically, the absence of fever affords no special indication. Antipyretics—salicylic acid, quinine, antipyrin, thallin, etc.—have been found to cause elevation of temperature. Quinine seems to have been used to the best advantage.—*L'Abeille Médicale*, 1894, No. 50, p. 399.

THE PATHOLOGICAL ANATOMY OF DIPHTHERITIC PARALYSIS.

PREISZ (*Deutsche Zeitschrift für Nervenheilkunde*, 1895, No. 6) describes the changes found in the spinal cord and the peripheral nerves in three cases of diphtheritic paralysis, two being general and one localized to the pharynx and heart. The first case showed atrophy of the ganglion-cells in the anterior horns, hemorrhage in the gray substance, and degeneration in various peripheral nerves and in the anterior and posterior roots of the cord. There were also peculiar changes in some of the peripheral nerves, which the author thinks identical with alterations described by Kopp in the peripheral nerves of dogs after extirpation of the thyroid, and by Langhans in cachexia thyreopriva in men and monkeys. It is not yet known whether these interfere with the functions of the nerves. In another case there was extensive degeneration of the posterior root in the lumbar cord and in the left column of Goll, and a slight degeneration of the right column of Goll in the cervical portion, secondary to a focus in the posterior roots of the cervical and upper dorsal cord. There was also atrophy of the ganglion-cells of the anterior horn. In the third case the vagi and glosso-pharyngeal nerves were extensively degenerated; the phrenics and the intermuscular nerve-trunks of the palatal and pharyngeal muscles were less severely affected. In this case death occurred on the seventeenth day after diphtheria. From these results it appears that in general post-diphtheritic paralysis the central and peripheral nerves are affected simultaneously. The ataxias noticed in such cases are explained by the changes in the posterior roots and columns.

A GASTRIC EQUIVALENT OF MIGRAINE.

BARY (*Neurologisches Centralblatt*, 1895, No. 6, p. 251) reports a case which he thinks illustrates an "equivalent" of migraine in the sense of Liveing and Möbius, or a "nerve-storm" corresponding to an attack of migraine, but differing in its location. The patient was a woman, aged fifty-one years, with a family history of dementia and various neuroses. From her ninth year the patient had attacks of headache every three or four weeks, brought on by various irritations or spontaneously. The attacks varied in intensity up to the most severe, with the other symptoms of migraine. There was no aura. Suddenly, and without apparent cause, pain appeared in the epigastric region. It came on almost every day, sometimes several times in a day, lasting one or two hours and disappearing suddenly. Besides eructation at the end of the attacks there were no other symptoms on the part of the stomach or intestines. During three months, while this condition lasted, there was no headache, but after the epigastric pain suddenly stopped migraine again began. Two years later the headache again ceased for two months, and the epigastric pain reappeared for the same period. A son of the patient had mild attacks of migraine. As there was no evidence of stomach disease, or of hysteria or neurasthenia, and as the attacks alternated with those of migraine, the author thinks they can only be explained as above.

THE PERCENTAGE OF IRON IN THE LIVER IN ANKYLOSTOMIASIS.

As the result of a series of analyses, RAKE (*Journal of Pathology and Bacteriology*, vol. iii., No. 1, p. 107) found that in ankylostomiasis the average percentage of iron in the liver is less than in other diseases, and is very much less than the average percentage in pernicious anæmia. Thus, in ankylostomiasis it is 0.1 per cent.; in other diseases, 0.12 per cent.; and in pernicious anæmia, 0.7 per cent. The iron in the spleen is scarcely affected in ankylostomiasis; the intense anæmia associated with this condition is simply due to loss of blood from the intestine, and is not caused by any toxic blood-destruction in the liver.

HYSTERICAL SYNCOPE, HEMIANÆSTHESIA, AND RAPID BREATHING.

BURR (*University Medical Magazine*, vol. vii., No. 5, p. 334) has reported the case of a woman, forty years old, who, while submitting to an application of a 10 per cent. solution of cocaine to a sensitive tonsil, suddenly grew pale and lost consciousness, while the breathing became very shallow and the lips cyanosed. The heart was weak and fluttering, and the pulse scarcely perceptible. On subsequent examination it was found that the right arm and leg were perfectly analgesic, while the sense of pain was impaired, though not abolished, on the right side of the face. Common sensibility was also impaired in these same regions. Pressure upon the supraorbital and infraorbital notches and upon the seventh nerve on the right side of the face, and upon the great occipital nerve, was painful. The breathing was exceedingly rapid and shallow and of upper costal type, but regular. Its frequency varied between 48 and 60, and was subject to abrupt variations. An attempt